22251

Tuberculosis Clinic Record

Spokane Regional Health District

Lab #: _____ KIPHS # _____

Last Name: _____ First: _____ MI: ____ Birthdate: _____ Age: ____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alternative Phone: _____ SS#: _____

Marital Status: ☐ S ☐ M ☐ D ☐ W ☐ Separated Gender: ☐ Female ☐ Male

Medicaid Eligible? ☐ Yes ☐ No If Yes, copy provided to Client Services. ☐ Yes By: _____ (initials)

Insurance Coverage? ☐ Yes ☐ No If Yes, Who: _____ Paid Prescription Coverage? ☐ Yes ☐ No

Race/Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Asian _____ (specify) ☐ Native Hawaiian

☐ Native American _____ (tribe) ☐ Pacific Islander _____ (specify) ☐ Alaskan Native

Primary Language - English?: ☐ Yes ☐ No If No, _____ (specify) interpreter needed.

Occupation:

- ☐ Unemployed >24 MOS
- ☐ Corrections Employee
- ☐ Migrant Farm Worker
- ☐ Retired
- ☐ Healthcare
- ☐ Other (Specify):

☐ Employer's Name:

Risk Factors: (mark all that apply)

- ☐ None ☐ History of incarceration ☐ Intestinal Bypass
- ☐ HIV ☐ Homelessness ☐ Immunosuppressed
- ☐ Silicosis ☐ Diabetes Mellitus ☐ End Stage of Renal Disease
- ☐ History of injection drug use/substance abuse
- ☐ Blood Disorder (Myeloproliferative disorders, leukemias, lymphomas?)
- ☐ Cancer If yes, what was the location?
  - ☐ Head ☐ Neck ☐ Lung ☐ Other Please List:
- ☐ Foreign-borne Country of Origin:
  - Month & Year of Arrival:
  - Alien #: Class: ☐ A ☐ B1 ☐ B2

Risk Factors for Liver Toxicity

- ☐ None ☐ Alcohol (> 10 drinks/week)
- ☐ Chronic Liver Disease ☐ Hepatitis B Vaccine Series
- ☐ Hx Hepatitis B or C (Please Check) ☐ Hep B ☐ Hep C
- ☐ Other:

HIV Risk Assessment:

Been Tested? ☐ Yes ☐ No

If yes, when?

Referred for testing? ☐ Yes ☐ No

If yes, where?

Risk Factors Assessed? (IDU, MSM, Prtnr HIV+,Sex for $/Drugs) ☐ Yes ☐ No

Current Medications: (Specify Name, Dose &Frequency)

- ☐ None
- ☐ Steroids:
- ☐ Antiseizure Meds:
- ☐ Anticoagulants:
- ☐ Methadone:
- ☐ Tumor Necrosis Factor Alpha
- ☐ Other Medications:
- ☐ Allergies:
- ☐ No Known Allergies

Current Symptoms:

- ☐ None
- ☐ Cough If yes, how long? Productive? ☐ Yes ☐ No
- ☐ Hemoptysis (blood in sputum) If yes, how long?
- ☐ Fever If yes, how long?
- ☐ Night Sweats If yes, how long?
- ☐ Unusual Fatigue If yes, how long?
- ☐ Weight Loss If yes, how much?
- ☐ Anorexia (loss of appetite) If yes, how long?
- ☐ Dyspnea (shortness of breath) If yes, how long?
- ☐ Chest Pain If yes, any history of heart pbs?
- ☐ Hoarseness If yes, how long?
- ☐ Any Other Health Pbs.

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Tuberculosis History

History of BCG:
☐ Yes
☐ No
If yes, when?

Testing:
☐ Skin
PPD Applied: (Date)
PPD Read: (Date)
Results: mm
☐ QFT-G
Blood Draw: (Date)
Results:
Facility:

Previous Diagnosis of TB:
☐ NO
☐ Latent, untreated Year DX:
☐ Latent, treated Year DX:
Medications:
☐ Active, untreated Year DX:
☐ Active, treated Year DX:
Medications:

Reason for Referral:
☐ Symptoms of TB ☐ Refugee/Immigration Exam
☐ Contact to Case: (name)
☐ TB Suspect Referral (facility)
☐ Drug Tx Program Referral (facility)
☐ Homeless Shelter Referral (facility)
☐ Jail Referral (facility)
☐ PMD Referral
Name:
Phone:
☐ Other

Previous Tests:
PPD:
☐ No
☐ Yes (Date) mm (results)
Facility:
Chest X-ray:
☐ No
☐ Yes (Date) Requested: ☐ Yes ☐ No
Facility:
Other:
(specify type, facility)

Tobacco Use:
☐ Never
☐ Former Packs/day
Quit # Yrs ago
☐ Current Packs/day

Women's Health:
☐ Post menopause
☐ LMP (Date)
☐ Advised to avoid pregnancy
☐ Pregnant Trimester (check) ☐ 1st ☐ 2nd ☐ 3rd
☐ Contraception Method

Education & Follow-up

☐ Provided education on TB disease, or latent TB infection.
☐ Discussed medication requirements or recommendations.
☐ Current weight lbs kgs
☐ TB MD clinic appointment for:
(Date/time)
☐ Client viewed video on INH.
☐ Sent to Inland Imaging for chest X-ray

Consent for Treatment:

I consent to examination, diagnostic testing and treatment services provided by the Spokane Regional Health District.

Signature: _____ Date: _____

Date: _____ Nurse signature: _____

Revised 5/22/2006 for QFT-G screening purposes